STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 89038-001**
v

Blue Care of Michigan, Inc.
Respondent
_____/

Issued and entered
This 23rd day of June 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 8, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On April 15, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request.

The case involves medical issues so the Commissioner assigned it to an independent review organization (IRO) which provided its recommendation to the Commissioner on April 29, 2008.

II
FACTUAL BACKGROUND

Blue Care of Michigan, Inc. (BCMI) is an alternative delivery system under Section 3573 of the Insurance Code of 1956, MCL 500.3573, and is subject to the provisions of Chapter 35 of the Code.

The Petitioner has nongroup coverage from BCMI that was effective April 1, 2007. Her health care benefits are defined in the BCMI Personal Plus certificate of coverage (the certificate). The certificate has a pre-existing conditions clause that excludes coverage for any condition for which the member sought advice or treatment in the six-month period prior to the effective date of coverage.

On July 24, 2007, the Petitioner saw her OB/GYN, because of severe pelvic pain. He recommended surgery and on August 17, 2007, she had a hysterectomy.[1] The charges totaled $9,591.05. BCMI initially paid the claims but later recovered the payments, saying the services were for a pre-existing condition and are therefore excluded under the terms of the certificate.

When the Petitioner asked BCMI to reprocess the claims and make payments to her providers, BCMI declined. The Petitioner appealed and after exhausting BCMI's internal grievance process, received its final adverse determination letter dated March 24, 2008.

III
ISSUE

Did BCMI properly deny coverage for the care the Petitioner received from July 24 to August 20, 2007, under the pre-existing conditions provision in the certificate?

IV
ANALYSIS

Petitioner's Argument

In February 2007, the Petitioner had her annual pelvic exam and a Pap test that was negative. In June 2007 she saw Dr. XXXXX, her primary care physician, because she was experiencing severe pelvic pain and spotting. She returned to Dr. XXXXX on July 21, 2007, because she was still spotting and her pain had not improved.

On Dr. XXXXX's recommendation, the Petitioner saw Dr. XXXXX, an OB/GYN, on July 24, 2007. She was having pain and post-menstrual bleeding, and according to the

[1] The Petitioner also had additional services (abdominoplasty, liposuction, and thigh lift) that she paid for that are not at issue in this review.

Petitioner, Dr. XXXXX determined she had uterovaginal prolapse and recommended surgery. BCMI authorized coverage and the surgery included a total abdominal hysterectomy, bilateral salpingo-oophorectomy, and Burch sling. (BCMI subsequently reversed its authorization.)

The Petitioner contends the services were not for a pre-existing condition and wants BCMI to reprocess the claims and cover the services related to her hysterectomy.

Respondent's Argument

BCMI initially covered the Petitioner's surgery but later requested medical records and, after reviewing them, decided that coverage was not appropriate and recalled its payments to the Petitioner's providers. BCMI said in its final adverse determination that coverage was denied because "the requested services are considered [related to] a pre-existing condition and not covered under your Personal Plus policy."

Commissioner's Review

The Petitioner's certificate contains this pre-existing conditions limitation on pages 15-16:

> **IX. SCHEDULE OF BENEFITS**
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> **9.01 GENERAL RESTRICTIONS**
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> *** * ***
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> B. PRE-EXISTING CONDITIONS: There is no coverage under this Certificate for six months after the effective date of coverage for any and all conditions for which medical advise [*sic*], diagnosis, care or treatment was recommended or received within six months before the effective date of coverage. The term "conditions" includes, but is not limited to, maternity or obstetrical care, or termination of pregnancy.

This provision is permitted in nongroup certificates by Section 3539 of the Insurance Code, MCL 500.3539. In the Petitioner's case, it excludes coverage during the first six months after the effective date of her coverage (from April 1 to October 1, 2007) for any conditions for which medical advice, diagnosis, care, or treatment was recommended or received within six months before the effective date of her coverage (from October 1, 2006, to April 1, 2007).

To help the Commissioner resolve the issue of whether BCMI's denial of coverage was correct, the matter was assigned to an IRO for the recommendation of an expert. The IRO reviewer is certified by the American Board of Obstetrics and Gynecology and is in active clinical practice. The IRO report said in part:

> The Reviewer noted that this 48-year-old female was followed by a physician from January, 2006 through August 1, 2007. On July 24, 2007, the [Petitioner] saw her gynecologist complaining of back pain and stress urinary incontinence. The [Petitioner] had a pre-existing condition of post-menopausal spotting. She had a normal PAP smear and normal endometrial biopsy.
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> On August 20, 2007, she underwent total abdominal hysterectomy with bilateral salpingo-oophorectomy; Burch sling; sacroplexy; abdominoplasty; liposuction; thigh lift. The Reviewer commented that surgery performed was secondary to pelvic pain; not the history of bleeding. The Reviewer acknowledged that the work-up for [the Petitioner's] bleeding was appropriate and the results were normal.
>
> In the opinion of the Reviewer, the surgery performed was for a new condition and not from a pre-existing condition.

The IRO reviewer's recommendation, based on extensive expertise and professional judgment, is afforded deference by the Commissioner. The Commissioner can discern no reason why the IRO reviewer's judgment should be rejected in the present case.

Therefore, the Commissioner accepts the IRO reviewer's conclusion that the services the Petitioner received from July 24 to August 20, 2007, related to the stress urinary incontinence and for her hysterectomy were not to treat a pre-existing condition, and finds that BCMI's denial of coverage on that basis was not consistent with the certificate. BCMI incorrectly recovered the payments it paid to the Petitioner's providers.

V
ORDER

Respondent BCMI's March 24, 2008, final adverse determination is reversed. BCMI shall approve coverage for the services the Petitioner received from July 24 to August 20, 2007, related to the stress urinary incontinence and hysterectomy, subject to any applicable terms and

conditions of the certificate within 60 days of the date of this Order. BCMI shall, within seven days of providing coverage, present the Commissioner with proof it has implemented the Commissioner's Order.

To enforce this Order, the Petitioner must report any complaint regarding the implementation of this Order to the Office of Financial and Insurance Regulation, Health Plans Division, toll free 877-999-6442.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.